

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4382

CERTIFICATE OF DEATH

64329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		c. LENGTH OF STAY IN 1b 84 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Goldsboro	
3. NAME OF DECEASED (Type or print) Edward		First H.	Middle Clark
4. DATE OF DEATH 4	Month 17	Day 19	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-1875
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 218-10-8436A	17. INFORMANT Address Carroll Clark Kennett Square Pa.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerotic Cardiovascular Dis.</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) <i>Arteriosclerotic Cardiovascular Dis.</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Bronchitis, Nutritional Anemia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar. 10 , 19 50 , to April 17 , 19 60 , that I last saw the deceased alive on April 17 , 19 60 , and that death occurred at 4 M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles H. Stoenifer</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>Charles H. Stoenifer, M.D.</i> DATE SIGNED Apr. 18, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-20-60	22c. NAME OF CEMETERY OR CREMATORIAL Greensboro
22d. LOCATION (City, town, or county) (State)		Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire Greensboro Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE APR 25 '60
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BT-BROMITAS-PITMAN TO THE UNITED STATES OLYMPIC TEAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G262 5/12/60 iwk

4383

CERTIFICATE OF DEATH

64330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	b. COUNTY <i>CAROLINE</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Route 2 Box 186</i>	e. STREET ADDRESS <i>Route 2, Box 186</i>	d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Fred</i>	First <i>F</i>	Middle <i>M</i>	Last <i>DYER</i>
4. DATE OF DEATH <i>4</i>	Month <i>4</i>	Day <i>14</i>	Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1890</i> <i>4/17/178891</i>
9. AGE (In years last birthday) yrs. <i>70</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>FARMer</i>	11. BIRTHPLACE (State or foreign country) <i>MARYland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Phillip Dyer</i>	14. MOTHER'S MAIDEN NAME <i>Alice thomas</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i> </i>	17. INFORMANT <i>Willie Dyer, Denton, md.</i>	Address <i> </i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>23 IX</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i> </i>		INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i>	
DUE TO (b) <i>Hypertension</i>		1 Year	
DUE TO (c) <i> </i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan.</i> , 19 <i>60</i> , to <i>Apr. 14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Apr. 14</i> , 19 <i>60</i> , and that death occurred at <i>326A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. L. Small MD</i>		ADDRESS (Street, city or town, state) <i>Denton, Md.</i> DATE SIGNED <i>4-15-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIA</i>		22b. DATE THEREOF <i>4/18/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St Paul Cemetery</i>
22d. LOCATION (City, town, or county) <i>Denton Rt. 2, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James D. Dashiell, Denton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 21 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WALTERS LIBRARY OF THE AMERICAN RAILROAD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4379

CERTIFICATE OF DEATH

64331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>CAROLINE</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DENTON</i>		c. LENGTH OF STAY IN 1b <i>X Denton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>/</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>BERTIE</i>	Middle <i>MARTHA</i>	Last <i>HARRIS</i>
4. DATE OF DEATH	Month <i>APR</i>	Day <i>9</i>	Year <i>1960</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 13, 1910</i>
9. AGE (In years last birthday) <i>49</i>	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Samuel Pollard</i>	14. MOTHER'S MAIDEN NAME <i>J</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Raymond Harris, Denton, Md.</i>	Address <i>Denton, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Uterus and Ovary</i> <i>174X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Denton</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>55</u> , to <u>April 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>60</u> , and that death occurred at <u>la.</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D. PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u> ADDRESS (Street, city or town, state) <u>Denton, Md.</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr. 11, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>	22d. LOCATION (City, town, or county) (State) <i>Denton, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wright recovered for Denton</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>APR 19 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

174X

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4381

64382

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Collins Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maude		First B.	Middle Harris
4. DATE OF DEATH 4 17 1960	Month 4	Day 17	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1883
9. AGE (In years lost birthday) 76	10. IF UNDER 1 YEAR Months 76	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. S. Pennell	14. MOTHER'S MAIDEN NAME Mary Emma Coleman	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT George W. Harris Ridgely, Maryland	18. INTERVAL BETWEEN ONSET AND DEATH 6 days
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (left Hemiplegia) . DUE TO Arteriosclerotic heart disease.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 15 to April 16 , 1960, that (I) (we) last saw the deceased alive on April 16 , 1960, and that death occurred at 5:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott		22b. DATE SIGNED 4/21/60	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott M.D.	M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Ridgely, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-20-60	23c. NAME OF CEMETERY OR CREMATORIAL Chester	23d. LOCATION (City, town, or county) (State) Chestertown, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boosalis Greensboro, Md.	ADDRESS	25a. REC'D BY REGISTRAR APR 25 '60	25b. REGISTRAR'S SIGNATURE C. C. - 2 K. Knud

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4384

CERTIFICATE OF DEATH

64333

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Ridgely	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Emmett Last Lynch		4. DATE OF DEATH Apr. 22, 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1894
9. AGE (In years lost birthday) yrs. 65		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mail carrier		10b. KIND OF BUSINESS OR INDUSTRY Postoffice	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Lynch		14. MOTHER'S MAIDEN NAME Elizabeth Bechtel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) Yes		16. SOCIAL SECURITY NO. WW2 216-38-7724	
17. INFORMANT Mrs. William E. Lynch, Ridgely, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Hidden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		7 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1953, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 11:45 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Kurt Lederer M.D.		DATE SIGNED Queen Anne, Maryland 4/25	
PHYSICIAN'S NAME (Type) Kurt Lederer M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Apr 26, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Denton	
22d. LOCATION (City, town, or county) Denton, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Moore Denton		24a. REC'D BY REGISTRAR APR 28 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

87 PROMISES MADE TO THE UNITED STATES GOVERNMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4385

CERTIFICATE OF DEATH

64334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Gary	Middle Wayne	Last Murphy	4. DATE OF DEATH	Month Apr.	Day 9	Year 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1960	9. AGE (In years from last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Murphy		14. MOTHER'S MAIDEN NAME Elizabeth Poist					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Robert Murphy, Hillsboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause lost.		inflammation of the colon		INTERVAL BETWEEN ONSET AND DEATH 1 day			
(b) DUE TO Mega colon						pneumal	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hillsboro	(County) (State)
21. I certify that I attended the deceased from <u>March 31, 1960</u> , to <u>April 9, 1960</u> , that I last saw the deceased alive on <u>April 9, 1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 4/11/60	
ACTUAL SIGNATURE Kurt Lederer		M.D.					
PHYSICIAN'S NAME (Type) Kurt Lederer M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 10, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount	22d. LOCATION (City, town, or county) Hillsboro, Md.			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Kraus		ADDRESS Baltimore, Md.	24a. REC'D BY REGISTRAR APR 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 may be used with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55

Noss

14 U.S.C. § 1601 et seq.; 16 U.S.C. § 1601 et seq.; 16 U.S.C. § 1601 et seq.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4380

CERTIFICATE OF DEATH

64385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	
3. NAME OF DECEASED (Type or print) <i>First</i> <i>Frank</i> <i>Middle</i> <i>Lefroy</i> <i>Last</i> <i>Kuttle</i>		4. DATE OF DEATH Month <i>April</i> Day <i>24</i> Year <i>1960</i>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 11 1875</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>2</i> Days <i>13</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nucleat</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William B. Kuttle</i>		14. MOTHER'S MADDEN NAME <i>Addie F. Wulansen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown)		16. SOCIAL SECURITY NO. <i>200-46-3411</i>	
17. INFORMANT <i>Elias G. Kutte</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sensitity -</i> (c) <i>Shock due to fall</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>24 hr -</i>	
		4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>9</i> a. m. <i>4:22</i> p. m. <i>1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Denton</i> (County) <i>Caroline</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Sept.</i> 19 <i>51</i> , to <i>April 24</i> 19 <i>60</i> , that I last saw the deceased alive on <i>April 24</i> , 19 <i>60</i> , and that death occurred at <i>7:32 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dawson O. George</i>		ADDRESS (Street, city or town, state) <i>Denton Md.</i> DATE SIGNED <i>4-25-60</i>	
PHYSICIAN'S NAME (Type) <i>DAWSON O. George</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>4/26/60</i>		22b. DATE THEREOF <i>4/26/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>		22d. LOCATION (City, town, or county) <i>Denton</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Denton Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 28 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

87 BROWNLAW—NEW YORK STATE COURT OF APPEALS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4386

CERTIFICATE OF DEATH

Reg. Dist. No. 64307

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON	c. LENGTH OF STAY IN 1b 40 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON	d. STREET ADDRESS X		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN	First: JOHN	Middle: Houston	Last: Houston Thawley Jr.		
4. DATE OF DEATH Apr. 11 1960	Month: Apr.	Day: 11	Year: 1960		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1896		
9. AGE (In years last birthday) yrs. 63	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner	11. KIND OF BUSINESS OR INDUSTRY Farming	12. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME JOHN HUSTON THAWLEY SR.	14. MOTHER'S MAIDEN NAME Sydia Parris	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 163 X 171	17. INFORMANT Wm. Houston Thawley	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic Carcinoma of the Cervical Spine			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Denton	20f. (City or town) Denton	(County) Carroll	(State) Md.
21. I certify that I attended the deceased from June 13, 1959 , to April 11, 1960 , that I last saw the deceased alive on April 10, 1960 , and that death occurred at 12:20 PM ; from the causes and on the date stated above.					
ACTUAL SIGNATURE Charles H. Stonesifer M.D.	ADDRESS (Street, city or town, state) Greensboro, Md.			DATE SIGNED Apr. 11 1960	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Apr. 14, 1960	22b. DATE THEREOF Apr. 14, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Denton	22d. LOCATION (City, town, or county) Denton, Md.	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wright Coopersburg Denton, Md.	ADDRESS Denton	24a. REC'D BY REGISTRAR Arthur S. Kraus	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	DATE APR 18 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA—DEPARTMENT OF REVENUE AND TAXATION

163X